

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for CPT code 95900.
- b. The request was received on August 19, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on September 16, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on September 18, 2002. The response from the insurance carrier was received in the Division on October 8, 2002. Based on 133.307 (i) the insurance carrier's response is untimely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Position statement not included with submitted additional information.
2. Respondent: Response submitted untimely.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is August 22, 2001.
2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
08/22/01	95900 (12)	\$768.00	\$64.00	F	\$64.00/nerve x 12 = \$768.00 - \$64.00 = \$704.00	CPT Descriptor MFG, MGR (IV)(4)	Requestor did not provide an interpretation of the results of the study documenting that 12 nerves were tested. Documentation does not support the level of service billed; therefore, no additional reimbursement is recommended.
Totals		\$768.00	\$64.00				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 10th day of February 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf